Practitioner Data Form

Instructions:

- Information on this Data Form must be provided and completed in its entirety for each Practitioner seeing patients within the Group or Facility.
- Please submit a copy of the Provider's W-9 (one per tax entity).
- Please make copies and attach additional Location Information pages, if necessary.
- Please ensure to include the Medicaid ID number.
- Please attach the Ownership and Disclosure Form.
- If a Practitioner participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

Date Completed:	**Individual NPI:**	
Are you registered with CAQH? ❑ **Yes** ❑ **No**	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID (11 digits):**
Medicare #		
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
Has Provider completed Cultural Competency Training? ❑**Yes** ❑**No**		
If Yes, did the training include the following? **African American-** ❑**Yes** ❑**No** **Asian -** ❑**Yes** ❑**No** **Alaskan Native-** ❑**Yes** ❑**No** **Hispanic/Latino-** ❑**Yes** ❑**No** **American Indian-** ❑**Yes** ❑**No** **Pacific Islander-** ❑**Yes** ❑**No** **Other** ____________ ❑**Yes** ❑**No**		

Billing Information (Complete this section if different than the W9):

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	**City State, Zip:**	**Phone Number :**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Location Information 1 of ____

Location Name:	Group NPI:	Tax ID:
Location Street Address:	Location City/State:	Location Zip Code:
Location County:	Primary Phone:	Primary Fax:

Email Address:	Website URL: (www.)

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ❑ Specialist (includes Behavioral Health)
❑Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	Taxonomy:	Display in Find-A-Provider? ❑Yes ❑ No	Languages Spoken (including American Sign Language):

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

❑ 24 Hours ❑ 8 – 5 Monday - Friday

License Number:	License State:	Exp. Date:
Are you board certified? ❑Yes ❑ No	If yes, board name:	Exp. Date:

If PCP, are you accepting new patients? ❑ Yes ❑ No ❑Yes, existing patients only	Gender or Age restrictions? Gender: ❑ None ❑ Female Only ❑ Male Only Ages treated: ❑ None ❑ Age Limits: Lowest Age ____ Highest Age ____ Ages treated for Psychiatrists/Psychologists who treat child/adolescent members: ❑ 0-6 ❑ 7-12 ❑ 13-17 ❑18-21

Are the following areas in your office ADA Compliant? (Check all that apply)
❑Building ❑ Bathroom(s) ❑ Therapy Room(s) ❑ Parking ❑ Equipment

Location Information _____ of _____

Location Name:	Group NPI:	Tax ID:
Location Street Address:	Location City/State:	Location Zip Code:
Location County:	Primary Phone:	Primary Fax:

Email Address:	Website URL: (www.)

Credentialing Contact Information (Name, Address, E-mail):

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